STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING _____ B. WING _____	C 04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00106736. This visit resulted in an Immediate Jeopardy - Past Non-Compliance. Complaint IN00106736 - Substantiated. Federal/state deficiencies related to the allegations are cited at F-371. Survey Date: April 10, 2012 Facility number: 000167 Provider number: 155266 AIM number: 100273740 Survey team: Angela Strass, RN, TC Rick Blain, RN Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 8 Medicaid: 57 Other: 8 Total: 73 Sample: 4 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review 4/13/12 by Suzanne Williams, RN	F 000		
F 371 SS=K	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING _____ B. WING _____	C 04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 1 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure food was served in a sanitary manner, related to broken glass in pureed food, for 6 of 10 residents who were receiving a pureed diet. (Residents #3670, 3663, 3767, 3826, 3710 and 3875) The Immediate Jeopardy began on 4/04/12 when the facility failed to remove and prepare new pureed food which had been contaminated by broken glass. The Director of Nursing (DON) and Regional Vice President were notified of the immediate jeopardy at 3:40 p.m. on 4/10/12. The Immediate Jeopardy was removed, and the deficient practice corrected, on 4/05/12, prior to the start of the survey and was therefore Past Noncompliance. Finding includes: On 4/10/12 at 8:30 a.m. during the entrance conference, the DON (Director of Nursing) indicated the facility had an incident which a glass	F 371	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING _____ B. WING _____	C 04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 2	F 371		

had been broken in the kitchen during the evening meal service and had been found in resident food. The DON provided the following incident details, dated 4/4/12 at 5:45 p.m.:

On 4/4/12 at 5:43 p.m. the DON (Director of Nursing) received a call from nurse #1 and stated that resident 3767 had a piece of broken glass in her pureed food. She indicated a CNA (certified nursing assistant) had fed the resident and on her last bite of food found a piece of glass. The DON spoke to the cook who indicated a glass had broken over the pureed food and they thought they had retrieved all of the glass out of the food. She informed the DON that a new batch of pureed food was made and being served. The DON spoke to nurse #1 again and instructed her to have staff inspect all the food before serving it to the residents and to assure anyone with pureed food had the new batch of pureed food. Nurse #1 later informed the DON that as soon as the glass was noted in resident #3767's pureed food, she alerted the cook and then went immediately to remove the pureed food from the residents in Beecher dining room. The Beecher dining room was the second dining room served. Two other residents who eat in Preston dining room and self feed had already consumed their pureed meal (Residents 3663 and 3670).

At 4/4/12 at 5:49 p.m. the Executive Director was notified regarding the incident. No new directives were given at that time.

On 4/4/12 at 6:02 p.m. Nurse #1 called the DON and simultaneously received a voice mail from nurse #2 stating that a second piece of glass was found in resident 3826's pureed food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING _____ B. WING _____	C 04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 3	F 371		

Investigation revealed nurse #2 noted the piece of glass when checking Beecher dining room pureed food. Resident 3826 had begun self feeding and had consumed 4-5 bites of food. The DON instructed nurse #1 to assure all pureed food was returned to the kitchen and that she was going to notify the Executive Director and would call back. Nurse #1 informed the DON that the Doctor was in the facility at the time and was aware of the situation at hand.

On 4/4/12 at 6:03 p.m. the Executive Director was notified regarding the second piece of glass found in the pureed food. The DON was instructed to contact the Dietary Manager regarding the situation.

On 4/4/12 at 6:06 p.m. the DON contacted the Dietary Manager and informed her of the situation. The Dietary Manager informed the DON she was on her way to the facility.

On 4/4/12 at 6:14 p.m. the DON called the facility and spoke to nurse #3 on Denton Hall (Denton Hall is the third and final dining room to be served). Because the DON could not ascertain at the time whether the pureed food resident 3826 was served was from the old or the new batch of pureed food, the DON instructed nurse #3 to designate one of her staff to go to the kitchen and observe a third batch of pureed food being made. (There are four residents that receive pureed food in the Denton dining room). It was later noted that two residents 3875 and 3710 self fed pureed food in their room and consumed the "new batch" of pureed food. The two residents received their trays last due to eating in their rooms and the hall trays were set up using the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING _____ B. WING _____	C 04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 4 "new batch" of pureed food. On 4/4/12 at 7:30 p.m. the DON received a call from nurse #1. Nurse #1 informed the DON that nurses were completing the incident reports and wanted to know what to tell the families. The DON instructed to defer calling families/responsible parties at that time and that management would contact them tomorrow. On 4/4/12 at 9:40 p.m. the DON went to the facility and spoke to nurse #1 and #2 regarding the events of the evening and the status of residents involved. Six residents had already been identified as having the need for further monitoring related to risk. Residents #3670, 3663, 3767, 3826, 3710 and 3875. The DON spoke with the nurses and instructed them to chart any noted bleeding from the mouth and/or rectum and to instruct CNAs to report any bleeding noted on the residents involved. On 4/5/12 in the morning, the DON instructed the ADON (assistant director of nursing) to have nurses working with identified residents to do a complete assessment of oral cavity and to identify any injury or bleeding, abdominal assessments to determine any pain/firmness and to assess rectal areas for bleeding. On 4/5/12 at 10:30 a.m. the Medical Director was in the facility. The DON updated him on the events of the last evening. The Medical Director again instructed to continue monitoring residents. The DON inquired about doing follow up CBCs (complete blood counts) on residents. The Medical Director agreed and stated they could be done tomorrow morning.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING _____ B. WING _____	C 04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 5 Documentation indicated, on 4/5/12 at 2:30 p.m., the DON reviewed all documentation in medical records for the involved residents. Residents on Coumadin (a blood thinner) were Resident #3670, who had a PT/INR (Prothrombin Time/International Normalized Ratio) drawn on 4/5/12 and had a repeat scheduled for 4/8/12, and Resident #3663 had PT/INR scheduled on 4/9/12. Interview with the Director of Nursing and the Dietary Manager on 4/10/12 at 1:30 p.m., indicated the top of the steam table had had a rolling rack which the dietary staff used for the trays. The dietary staff would put the glasses on the tray with the food. Interview and observation of the steam table at this time indicated the rack has been removed and the residents' glasses are now set at their tables. This Past Noncompliance Immediate Jeopardy began on 4/4/12. The Immediate Jeopardy was removed and the deficient practice corrected by 4/5/12 after the facility implemented a systemic plan that included the following actions: Dietary Staff were inserviced on contamination of food and beverage, the rolling tray line from above the steam table was removed, and the facility started placing glasses at the residents' tables on 4/05/12. The two dietary staff working in the kitchen on 4/4/12 at the time of the incident were suspended on 4/05/12 and have been terminated. This Federal Tag relates to Complaint IN00106736. 3.1-21(i)(3)	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING _____ B. WING _____	C 04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	**1649 SPY RUN AVENUE FORT WAYNE, IN 46805**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE